1 M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7,11,12,13 & 14 Film #G381 9/26/66 pc

12653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12648

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Washington Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
d. STREET ADDRESS: Old Washington Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Cecilia Boshitti — Middle — Lost — aka Alba Rosa Castro Boschitti

4. DATE OF DEATH: Month: Sept. — Day: 9 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salto. Uruguay

12. CITIZEN OF WHAT COUNTRY? Uruguay

13. FATHER'S NAME: none

14. MOTHER'S MAIDEN NAME: Ramona Boschetti-Castro

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Contact gunshot wound of head — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot herself in head

20c. TIME OF INJURY Month, Day, Year: Hour: 5:15 p.m. — 9-9 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Waldorf (County) Charles (State) Maryland

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 9-10-66

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: 9-15-66

23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory

23d. LOCATION (City or Town) Washington (County) (State) D.C.

24. FUNERAL DIRECTOR: Otis F. Allen — ADDRESS: 1200 Fla. Ave. N.W.
Jos. Brooks & Allen Funeral Home

25a. REC'D BY REGISTRAR DATE: SEP 19 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and no event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12649

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlotte Hall
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlotte Hall
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: TERESA Middle: JEAN Last: BUCKLER
4. DATE OF DEATH: Month: 9 Day: 6 Year: 1966

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-25-66
9. AGE (If under 1 year, last birthday) yrs.: IF UNDER 1 YEAR Months: 2 Days: 11; IF UNDER 24 HRS. Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Leonardtown, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clark Buckler
14. MOTHER'S MAIDEN NAME: Barbara Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Barbara Buckler — Address: Charlotte Hall Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable Suffocation — INTERVAL BETWEEN ONSET AND DEATH: 9-6-66
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): —
DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS: PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): found under overturned mattress
20c. TIME OF INJURY Month, Day, Year: Hour: a.m. p.m. 9-6-66
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Chas. Md

21. I certify that I took charge of the remains described above; held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward J. Edelen M.D.
EXAMINER'S NAME (Type): Edward J. Edelen
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): —
22. DATE SIGNED: 9-6-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-8-66
23c. NAME OF CEMETERY OR CREMATORY: All Faiths Episcopal
23d. LOCATION (City or Town) (County) (State): Charlotte Hall Chas. Md

24. FUNERAL DIRECTOR: McHuntt Funeral Home
ADDRESS: Waldorf Md.
25a. REC'D BY REGISTRAR DATE: SEP 9 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

6-19456

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12655 12650

1. PLACE OF DEATH
a. COUNTY: Charles
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LaPlata Md.
c. LENGTH OF STAY IN 1b: 24-Hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Physicians Memorial LaPlata Md

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Washington D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 4545-Connecticut Ave N.W
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Merrit Last Case
4. DATE OF DEATH: Month 9 Day 25 Year 1966
5. SEX: Male
6. COLOR OR RACE: W-US
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-1-1897
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Civil Service
10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Agri.
11. BIRTHPLACE (County & State, or foreign country): Etherville, Iowa
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: William A.Case
14. MOTHER'S MAIDEN NAME: Mary Verink
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): WW-1 (If yes give war or dates of service): 5-1919to6-1919
16. SOCIAL SECURITY NO.: 502--22-8377
17. INFORMANT: Robert A.Case, Address 6900 W. Elsworth St. Denver, Colo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24-Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (b): Arterio Sclerosis — Indefinite
DUE TO (c): Aging Process — Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ hospital) attended the deceased from 9-25-66, 19__, to 9-25-66, 19__, that (I) (we) last saw the deceased alive on 9-25-66, 19__, and that death occurred at 10-05-PM from the causes and on the date stated above.

22a. SIGNATURE: James E. Andrews M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-26-66
22c. PHYSICIAN'S NAME (Type): James E. Andrews MD
22d. ADDRESS: Indian Head Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-29-1966
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.
23d. LOCATION (City, town or county) (State): Arlington, Va.
24. FUNERAL DIRECTOR: Joseph Fowler's Sons
ADDRESS: Wash, D.C.
25a. REC'D BY REGISTRAR DATE: OCT 5 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12651

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nanjemoy (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD — Middle Lee — Last CUSICK
4. DATE OF DEATH: Month 9 — Day 3 — Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-25-36
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Goverment
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Horace W. Cusick
14. MOTHER'S MAIDEN NAME: Deloris (Unkown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 219-34-7511
17. INFORMANT: Mrs. Ella K. Cusick-Route #1, Box 106D — Address: Nanjemoy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Crushing Injuries — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): to entire body and
DUE TO (c): evicerations, Hit by auto — 9-3-66
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pedestrian - hit by auto
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Edelen M.D.
EXAMINER'S NAME (Type): E.J. Edelen, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): La Plata, Md.
22. DATE SIGNED: 9-3-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/6/1966
23c. NAME OF CEMETERY OR CREMATORY: Trinity Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Waldorf, Md.

24. FUNERAL DIRECTOR: Arehart Funeral Home, Inc.-La Plata, Md. — ADDRESS
25a. RECD BY REGISTRAR DATE: SEP 9 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12657 12652

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Plains
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Plains
d. STREET ADDRESS: DeMarr Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Claude Middle: LeRoy Last: DeMarr
4. DATE OF DEATH Month: Sept. Day: 1, Year: 19 66

5. SEX: Male
6. COLOR OR RACE: Cau.
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 9, 1892
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Tobacco
11. BIRTHPLACE (County & State, or foreign country): PRINCE GEO, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John T. DeMarr
14. MOTHER'S MAIDEN NAME: Margaret Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 217-36-8681
17. INFORMANT: Irene E. DeMarr, Address: White Plains, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): GENERAL VISCERAL FAILURE — 6 Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): INTESTINAL FLU — 12 Hours

DUE TO (c): EMPHYSEMA, CHRONIC, SEVERE — 10 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): GENERALIZED ARTERIOSCLEROSIS & SENILITY

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): /
20f. (City or town) (County) (State): /

21. I certify that (I) (this hospital) attended the deceased from 9/1/66, 19 to 9/1/66, 19 , that (I) (we) last saw the deceased alive on 9/1/66 19 , and that death occurred at 8 P M, from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Merkle M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 9-1-66
22c. PHYSICIAN'S NAME (Type): ROBERT W. MERKLE M.D.
22d. ADDRESS: Waldorf, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-5-66
23c. NAME OF CEMETERY OR CREMATORY: Trinity Mem. Gardens
23d. LOCATION (City, town or county) (State): Waldorf, Md.

24. FUNERAL DIRECTOR: The Huntt Funeral Home, ADDRESS: Waldorf, Md.
25a. REC'D BY REGISTRAR DATE: SEP 8 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 - Item #33 9/19/66 ps

0858

CERTIFICATE OF DEATH

12653

1 PLACE OF DEATH
a COUNTY CHARLES
MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) LA PLATA
c LENGTH OF STAY IN 1b: 1 day.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PHYSICIANS MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE [illegible] b COUNTY [illegible]
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or pr.) First: BRYAN Middle: DAVID Last:
4 DATE OF DEATH Month Day Year 19

5 SEX: Male.
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 3 Sept 66
9 AGE (In years last birthday) ___ yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours 21 Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ___
10b KIND OF BUSINESS OR INDUSTRY ___
11 BIRTHPLACE (County & State or foreign country) LA PLATA, MD.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arlie J. David Bryan
14 MOTHER'S MAIDEN NAME: Jessie Alice H. Lloyd

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Collapse of the respiratory Center — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Prematurity.
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from 3 Sept, 1966, to 4 Sept, 1966, that (I) (we) last saw the deceased alive on 4 Sept 19 66, and that death occurred at 4:30 P M, from causes and on the date stated above

22a. SIGNATURE: Arthur O. Woodby, M.D. M.D ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 4 Sept 66
22c. PHYSICIAN'S NAME (Type) ARTHUR O. WOODBY, M.D.
22d ADDRESS J. ARWOOD CLINIC, LA PLATA, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b DATE THEREOF
23c NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR [illegible] ADDRESS [illegible]
25a REC'D BY REGISTRAR DATE SEP 8 1966
25b REGISTRAR'S SIGNATURE [illegible] Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12659

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12654

1 PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY:

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Issue

c LENGTH OF STAY IN 1b:

c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Issue

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): La Plata Hospital

d STREET ADDRESS:

e IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: JAMES Middle: P. Last: Holton

4 DATE OF DEATH: Month: September Day: 4 Year: 19 66

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: April 14, 1941

9 AGE in years last birthday: 25 yrs

UNDER 1 YEAR: Months: Days: UNDER 24 HRS: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: Tompkins Cons.

11 BIRTHPLACE State or foreign country: Co. Rock Point, Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Joseph Holton

14 MOTHER'S MAIDEN NAME: Mary Hill

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service):

16 SOCIAL SECURITY NO: Unkown

17 INFORMANT: Mary Rita Holton-Wife-1608 E ST. N.E. Washington, D.C.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound of right thigh — INTERVAL BETWEEN ONSET AND DEATH:

9 1/X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18): Altercation with another man

20c TIME OF INJURY Month, Day, Year: Hour a.m. 1:45 — 9-4- 19 66

20d INJURY OCCURRED While at work [ ] Not While at work [X]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Tavern

20f (City or town) Issue (County) (State) Md.

21 I certify that I took charge of the remains described above held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county)

22. DATE SIGNED: September 5, 1966

23a BURIAL, CREMATION, REMOVAL: Burial

23b DATE THEREOF: 9/8/1966

23c NAME OF CEMETERY OR CREMATORY: Holy Ghost Cemetery

23d LOCATION (City or Town) Issue, (County) (State) Maryland

24. FUNERAL DIRECTOR ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.

25a RECD BY REGISTRAR DATE: SEP 9 1966

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5M) 6M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12655
Reg. Dist. No.

1360

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Pomonkey
c LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE Maryland b COUNTY Charles
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Pomonkey
d STREET ADDRESS
e IF FARM ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Alis Middle Lost Jackson

4 DATE OF DEATH Month Sept Day 27 Year 1966

5. SEX Male

6 COLOR OR RACE Negro

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH Unknown

9 AGE (In years at last birthday) 67 yrs
IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer

10b KIND OF BUSINESS OR INDUSTRY Pf

11 BIRTHPLACE (State or foreign country) Virginia

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME Lee Jackson

14 MOTHER'S MAIDEN NAME Josephine Frye

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service) No

16 SOCIAL SECURITY NO. 578-21-2600

17 INFORMANT Bertha Gibbson Address 437 Perrine Ave SE Wash DC

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest

DUE TO (b) Arteriosclerosis

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 4-27 1966

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) [illegible]

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 9-1-66

22a BURIAL CREMATION REMOVAL (Specify) Burial

22b DATE THEREOF Oct 1, 66

22c NAME OF CEMETERY OR CREMATORY Forest Lawn Cem

22d LOCATION (City, town, or county) Clinton (State) Md

23 FUNERAL DIRECTOR'S SIGNATURE Johnson Funeral Home, Pomonkey, Md ADDRESS

24a REC'D BY REGISTRAR DATE

24b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1

12656

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. PLACE OF DEATH
a. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIE; Middle; Last JOHNSON
4. DATE OF DEATH: Month September; Day 18; Year 66
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December 25, 1889
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (City & State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Thomas Johnson
14. MOTHER'S MAIDEN NAME: Henretta Chapman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: 220-40-2527
17. INFORMANT: Mr. Harry Johnson-Son Ironsides, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory - cardiac Collapse.
DUE TO (b): Embolism from gangrene leg -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Gangrene leg
INTERVAL BETWEEN ONSET AND DEATH: 5 min 20 min 10 days,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive heart failure.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE BELOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5 Sept 1966 to 18 Sept 1966, that (I) (~~we~~) last saw the deceased alive on 18 Sept 1966., and that death occurred at 6:45 PM, from the causes and on the date stated above

22a. SIGNATURE: A.O. Wooddy
22b. DATE SIGNED: 20 Sept 66
22c. PHYSICIAN'S NAME (Type): A.O. Wooddy, M.D.
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: La Plata, Maryland 20646

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/21/1966
23c. NAME OF CEMETERY OR CREMATORY: Church of Lord Jeasus Christ Cemetery, Ironsides
23d. LOCATION (City, town or county): Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.
25a. REC'D BY REGISTRAR DATE: SEP 22 1966
25b. REGISTRAR'S SIGNATURE:

VR A1S (4)
2DM 5-63

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12657

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata — c. LENGTH OF STAY IN 1b — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Charles — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata — d. STREET ADDRESS: Oak Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MABEL — Middle: Gibson — Last: JONES

4. DATE OF DEATH: Month: 9 — Day: 3 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-27-99

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William B. Gibson

14. MOTHER'S MAIDEN NAME: Ozella Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-54-5467

17. INFORMANT — Address: Dr. J.J. Jones- La Plata, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 9-3 E.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): T.E. TEDELEN — Address (Street, town, or county): La Plata, Md. — 22. DATE SIGNED: 9-3-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9/7/1966 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Rest Cemetery — 23d. LOCATION (City, town or county) (State): La Plata, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md. — 25a. REC'D BY REGISTRAR — DATE: SEP 9 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12658

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all events within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Wayside (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wayside (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: LUCINDA — Middle: — Last: JUPITER
4. DATE OF DEATH: Month: Sept — Day: 14 — Year: 1966
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug. 14, 1897
9. AGE (In years last birthday): 69 yrs
UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State or foreign country): Charles County, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Chapman
14. MOTHER'S MAIDEN NAME: (Unkown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: Unkown
17. INFORMANT: Margaret Cooper-Daughter- Address: Newburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CHRONIC BRONCHITIS — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(b): Pulmonary Hemorrhage — 1 Hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m.: 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-6, 1966 to 9-14, 1966, that (I) (we) last saw the deceased alive on 9-10 1966 and that death occurred at 5:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: J. M. Johnson M.D. — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 9-15-66
22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON
22d. ADDRESS: LA PLATA

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/17/1966
23c. NAME OF CEMETERY OR CREMATORY: Shilo M.E. Cemetery
23d. LOCATION (City or Town) (County) (State): Shilo, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.
25a. RECD BY REGISTRAR — DATE: SEP 19 1966
25b. REGISTRAR'S SIGNATURE: Stanley Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12559

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH — a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: 13
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PHYSICIANS MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) — a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): BEL ALTON
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: JOSEPH — Middle: FRANCIS — Last: NALLEY

4 DATE OF DEATH: Month: SEPT — Day: 4 — Year: 1966

5 SEX: Male

6 COLOR OR RACE: W

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8 DATE OF BIRTH: 7/08/10

9 AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Quarterman-Retired

10b KIND OF BUSINESS OR INDUSTRY: U.S.N.P.P.

11 BIRTHPLACE (County & State or foreign country): Charles County, Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William A. Nalley

14 MOTHER'S MAIDEN NAME: Jennie Lee Cash

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 213-40-9462

17 INFORMANT — Address: Mrs. Mildred Nalley-Bel Alton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Hemorrhage, primary, esophageal varix — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hepatic failure — 1 month.

DUE TO (c): Cirrhosis of the liver — 1 year.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 22 Aug, 1966, to 4 Sept, 1966, that (I) (we) last saw the deceased alive on 4 Sept 1966, and that death occurred at 12:40 P M, from causes and on the date stated above

22a SIGNATURE: Woodby. — M.D. — ATTENDING PHYS. ☐ — MED DIRECTOR ☒ — STAFF PHYS. ☐

22b DATE SIGNED: 4 Sept 66

22c PHYSICIAN'S NAME (Type): ARTHUR O WOODBY, MD

22d ADDRESS: JARWOOD CLINIC, LA PLATA, MD.

23a BURIAL CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 9/7/1966

23c NAME OF CEMETERY OR CREMATORY: St. Ignatius Cemetery

23d LOCATION (City or Town) (County) (State): Bel Alton, Maryland

24 FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.

25a RECD BY REGISTRAR — DATE: SEP 9 1966

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12660

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hospital
d STREET ADDRESS:

2. USUAL RESIDENCE (Where deceased lived. If inst tution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH: Month Sept. Day 12, Year 19[illegible]

5. SEX: [illegible]

6. COLOR OR RACE: [illegible]

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-15-92

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 577-40-3435

17. INFORMANT: HARRY C[illegible] Address: [illegible] WALDORF MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): E.J. Helen M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): La Plata, Md.

22. DATE SIGNED: 9-12-66

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR ADDRESS

25a. REC'D BY REGISTRAR DATE SEP 19[illegible]

25b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 7'65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12666

CERTIFICATE OF DEATH

12661

1 PLACE OF DEATH
a COUNTY (HAILES) MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
c LENGTH OF STAY IN this place: 16 Hrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): PHY MEM HOSPT

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a STATE Maryland b COUNTY Charles
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Haed
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First FREDERICK Middle WARFIELD Last POSEY
4 DATE OF DEATH: Month 9 Day 3 Year 1966
5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: September 2, 1966
9 AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours 16 Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (County & State or foreign country): CHAS Md
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: TERRY G POSEY
14 MOTHER'S MAIDEN NAME: JEANNE KOZAK
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: None
17 INFORMANT: Mrs C.W. POSEY Address: JULIAN HEAD Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hyalin Membrane disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 16 hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (the hospital) attended the deceased from 9-2-, 1966, to 9-3, 1966 that (I) (we) last saw the deceased alive on 9-3 1966, and that death occurred at 6 AM, from causes and on the date stated above

22a SIGNATURE: J. Johnson M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 9-3-66
22c PHYSICIAN'S NAME (Type): F.M. JOHNSON M.D
22d ADDRESS: LA PLATA, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 9-4-66
23c NAME OF CEMETERY OR CREMATORY: PARK HILL
23d LOCATION (City or Town) (County) (State): MARBURY CHAS Md

24 FUNERAL DIRECTOR: HEHART INC ADDRESS: LAPLATA Md
25a RECD BY REGISTRAR DATE SEP 7 1966
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending phys.cian.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please (carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12662

1 PLACE OF DEATH
a. COUNTY: Charles County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
c. LENGTH OF STAY IN 1b: 10-Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chapman's Landing Road

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head Md
d. STREET ADDRESS: Chapmans Landing Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Julia — Middle: Ethel — Last: Randle

4. DATE OF DEATH: Month: 9-12- — Day — Year: 19

5. SEX: Female

6. COLOR OR RACE: [illegible]

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: [illegible]-1886

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Otsego Iowa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible] J. Delmonde

14. MOTHER'S MAIDEN NAME: [illegible] J. Lindell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): [illegible]

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT — Address: T.I Randle.Son. Indian Head Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion-Massive — INTERVAL BETWEEN ONSET AND DEATH: Immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — Indefinite
DUE TO (c): Arterio Sclerotic Heart Disease — Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-6-1936, 19___, to 9-12-19[illegible], 19___, that (I) (~~not~~) last saw the deceased alive on 9-1-1966 19___, and that death occurred at 5:11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James E. Andrews M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 9-13-66

22c. PHYSICIAN'S NAME (Type): James E. Andrews MD — 22d. ADDRESS: Indian Head Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9/14/1966 — 23c. NAME OF CEMETERY OR CREMATORY: Jessops Mem. Church Cemetery — 23d. LOCATION (City, town or county) (State): Cockeysville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md. — 25a. REC'D BY REGISTRAR DATE: SEP 10 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12663

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

PLACE OF DEATH: a COUNTY: Charles; a STATE: MARYLAND	USUAL RESIDENCE (Where deceased lived if institution): a STATE: Maryland; b COUNTY: Charles
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Pomonkey; c LENGTH OF STAY IN b	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pomonkey
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e STREET ADDRESS; e IS RESIDENCE ON A FARM? YES ☐ NO ☒

1 NAME OF DECEASED (Type or print): First: Elroy; Middle: Antoine; Last: DAVIS	2 DATE OF DEATH: Month: Sept; Day: 6; Year: 66						
3 SEX: Male	4 COLOR OR RACE: Negro	5 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	6 DATE OF BIRTH: March 14 1961	7 AGE last birthday: 5 yrs	UNDER 1 YEAR: Months	Days	UNDER 24 HRS: Hours	Min
8a OCCUPATION (Give kind of work done during most of working life, even if retired)	8b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country): La Plata, Md.	12 CITIZEN OF WHAT COUNTRY?				
13 FATHER'S NAME: Robert Ransome	14 MOTHER'S MAIDEN NAME: Joan Mack						
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT: Joan Ransome	Address: Pomonkey Md.				

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(a) IMMEDIATE CAUSE: Multiple Crushing injuries Head - Chest

(b) DUE TO: Car Accident

(c) DUE TO:

INTERVAL BETWEEN ONSET AND DEATH: 9-6-66

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured Ankle

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18: Pedestrian hit by car				
20c TIME OF INJURY Month, Day, Year: Hour: 6 pm; 9-6-66	20d INJURY OCCURRED While at work ☐ Not While at work ☒	20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.): Road	20f (City or town): La Plata	County: Chas.	(State): Md.

21 I certify that I took charge of the remains described above held an Autopsy ☐, Inspection ☐, Injury ☐ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward J. Edelen M.D.

EXAMINER'S NAME (Type): Edward J. Edelen

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22 DATE SIGNED: 9-6-66

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: 9-9-66	23c NAME OF CEMETERY OR CREMATORY: Metropolitan Methodist Cem.	23d LOCATION (City or Town): Pomonkey	(County): Chas.	(State): Md.
24 FUNERAL DIRECTOR: The Hunt Funeral Home	ADDRESS: Waldorf, Md.	25a RECD BY REGISTRAR DATE: SEP 13 1966	25b REGISTRAR'S SIGNATURE: [illegible]		

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16339

CERTIFICATE OF DEATH

12661

1 PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITE PLAINS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITE PLAINS
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First: JULIUS — Middle: CORBIN — Last: KOBEY

4 DATE OF DEATH: Month: Sept. — Day: 1 — Year: 19 66

5 SEX: MALE

6 COLOR OR RACE: CAU

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: April 10, 1903

9 AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COMMISSIONER

10b KIND OF BUSINESS OR INDUSTRY: CHARLES County

11 BIRTHPLACE (County & State or foreign country): CHARLES, MARYLAND

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: MILTON KOBEY

14 MOTHER'S MAIDEN NAME: MATTIE E. CLEMENTS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): N/C

16 SOCIAL SECURITY NO: 217-36-9431

17 INFORMANT — Address: MRS. MARY E. KOBEY, WHITE PLAINS, MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): PULMONARY FIBROSIS (HAMAN-RICH DISEASE) — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):

20c TIME OF INJURY Month, Day, Year — Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6-11, 1966, to 9-1, 1966 that (I) (we) last saw the deceased alive on 8-23 1966, and that death occurred at 5:25 AM, from causes and on the date stated above.

22a SIGNATURE: F. M. Johnson M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐

22b. DATE SIGNED: 9-2-66

22c PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22d ADDRESS: LA PLATA, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 9-3-66

23c NAME OF CEMETERY OR CREMATORY: BIMPY OAK

23d LOCATION (City or Town) (County) (State): PISCATAWAY, MD

24 FUNERAL DIRECTOR: THE HUNTT FUNERAL HOME — ADDRESS: WALDORF, MD

25a REC'D BY REGISTRAR DATE: SEP 8 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12665

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac Heights
d. STREET ADDRESS: 88 Circle Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ronelea — Middle: Agnes — Last: Shaw

4. DATE OF DEATH: Month: 9 — Day: 6 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-2-52

9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Propelent Handler

10b. KIND OF BUSINESS OR INDUSTRY: U.S.N.P.P.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Darnell Griffin

14. MOTHER'S MAIDEN NAME: Agnes Kincheloe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-38-2685

17. INFORMANT: Mr. David M. Shaw-Husband- Address: Potomac Hgts, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest (Pulmonary TB)
DUE TO (b): Ca. of Transverse Colon
DUE TO (c):

Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Simple Bowel Obstruction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (This hospital) attended the deceased from 8/15, 19 66, to 9/2, 19 66, that (I) (we) last saw the deceased alive on 9/2 19 66, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Arthur M. Monteiro

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED: 9/11/66

22c. PHYSICIAN'S NAME (Type): A. M. Monteiro, M. D.

22d. ADDRESS: Box 807, La Plata, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/16/1966

23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Church Cemetery

23d. LOCATION (City, town or county) (State): Waldorf, Md.

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 13 1966

25b. REGISTRAR'S SIGNATURE: [illegible] Deputy Judge.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12566

PLACE OF DEATH a. COUNTY: Charles — MARYLAND	2. USUAL RESIDENCE (Where deceased lived if a visitor) a. STATE: Md. — b. COUNTY: Chas. —
b. CITY OR TOWN (Outside city limits, write RURAL and give nearest town): Pisgah Md	c. LENGTH OF STAY IN 1b: — — CITY OR TOWN (Outside corporate limits write RURAL and give nearest town): Pisgah —
d. NAME OF HOSP TAL OR INSTITUTION (If not hospital give street address): —	e. STREET ADDRESS: — — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: Ruth	Middle: A	Last: Simmons	4. DATE OF DEATH	Month: 9	Day: 21	Year: 1966	
5. SEX: F	6. COLOR OR RACE: C	7. MARRIED ☐ NEVER MARRIED ☐ W D WID ☐ DIVORCED ☐	8. DATE OF BIRTH: 5-11-00	9. AGE (In years last birthday): 66 yrs	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min

10. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	10E. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Charles County, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Reeder Jackson		14. MOTHER'S MAIDEN NAME: Elizabeth Chun	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT: Edward F. Coby	Address: Rt. 224-Waldorf, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 9-21-66

DUE TO (b): Art. Sclerosis —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E.F. Edelen M.D.

EXAMINER'S NAME (Type): E.F. EDELEN M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town or county): —

22. DATE SIGNED: 9-22-66

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9-24-66	Smith Chapel Ch. Cem.	Pisgah	Chas. Co.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE SEP	25b. REGISTRAR'S SIGNATURE
Mattie Adams Agnew	—		

VR A15ME (5) 6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12661

TO HOSPITAL OR OTHER PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CHS — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): S. CHARLES CLINIC

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA, MD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline — Middle: J. — Last: Thompson

4. DATE OF DEATH: Month: Sept — Day: 1 — Year: 1966

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-30-65

9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): CHARLES, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES L. THOMPSON

14. MOTHER'S MAIDEN NAME: MARY THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: CHARLES THOMPSON, WALDORF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ASPIRATION ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 2 MINUTES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ACUTE ENTERITIS WITH — 3 DAYS
DUE TO (c): ACIDOSIS — 24 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/31, 19__, to 9/1/66, 19__, that (I) (we) last saw the deceased alive on 9/1/66 19__, and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Merkle — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/1/66

22c. PHYSICIAN'S NAME (Type): ROBERT W. MERKLE

22d. ADDRESS: WALDORF, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9-2-66

23c. NAME OF CEMETERY OR CREMATORY: ST PETERS

23d. LOCATION (City, town or county) (State): WALDORF, MD

24. FUNERAL DIRECTOR — ADDRESS: McHATTIE-LAW HOME WALDORF, MD

25a. REC'D BY REGISTRAR — DATE: SEP 8 1966

25b. REGISTRAR'S SIGNATURE: James Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12668

1. PLACE OF DEATH
a. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicians Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Alton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EUGENE Middle JAMES Last THOMPSON

4. DATE OF DEATH: Month SEPT Day 20 Year 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 1, 1901

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Charles County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Thompson

14. MOTHER'S MAIDEN NAME: Elizabeth (Thompson)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give ver or dates of service): No

16. SOCIAL SECURITY NO.: 217-34-0134-A

17. INFORMANT Address: Mary E. Thompson-La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 7 wks.
DUE TO (b): ARTERIOSCLEROSIS — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-1-66 to 9-20-66, that (I) (we) last saw the deceased alive on 9-20-66 and that death occurred at 12M, from the causes and on the date stated above

22a. SIGNATURE: F. M. Johnson

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 9-22-66

22c. PHYSICIAN'S NAME (Type): F. M. JOHNSON MD

22d. ADDRESS: LA PLATA, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 23, 1966

23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Ceme.

23d. LOCATION (City, town or county) (State): Bel Alton, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Arehart Funeral Home Inc., La Plata, Md.

25a. REC'D BY REGISTRAR DATE: SEP 22 1966

25b. REGISTRAR'S SIGNATURE

VR A1S (4)
20M 5-63

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14096

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word pending in pencil in Item 18 Give Pages 1, 2 and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal from any event within 72 hours after death.

1 PLACE OF DEATH — COUNTY: Charles — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a STATE: Maryland — b COUNTY: Charles County

b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Ranjemoy Md

c LENGTH OF STAY IN 1b: 80

CITY OR TOWN (Inside corporate limits write RURAL and give nearest town): Nanjemoy Md

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

d STREET ADDRESS

e IS RES. ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (First, Middle, Last): Harry Joyer

4 DATE OF DEATH: Month 9 Day 27 Year 19 66

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8 DATE OF BIRTH: 2/-2/1886

9 AGE (Last birthday) Years

IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a OCCUPATION (Kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: John Joyer

14 MOTHER'S MAIDEN NAME: Fanny Grubb

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) No (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 213-16-24[illegible]

17 INFORMANT (Address): Mary F. Coats -Niece-Nanjemoy,Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Heart Disease (Occlusion) — INTERVAL BETWEEN ONSET AND DEATH: Immediate

4201

Conditions if any which gave rise to immediate cause (a) stating the underlying cause last

DUE TO (b): Arterio Sclerosis General — Indefinite

DUE TO (c): [illegible] Process — Indefinite

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER: [signature] M.D

EXAMINER'S NAME (Type or print): James T. Andrews M.D. Indian Head Md.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county)

22 DATE SIGNED: 9-27-66

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 10/1/1966

23c NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery

23d LOCATION (City or Town) (County) (State): Grayton , Maryland

24 FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home,Inc.-La Plata,Md.

25a REC'D BY REGISTRAR — DATE: OCT 10 1966

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12669

PLACE OF DEATH
a. COUNTY: Charles County — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town):
c. LENGTH OF STAY IN:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address):

2. USUAL RESIDENCE (Where deceased lived if not in hospital. Residence before admission.)
a. STATE: Unkown — b. COUNTY: Unkown
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town):
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: None — Middle: — Last: Unknown
4. DATE OF DEATH: Month: 9-1-66 — Day — Year — 19
5. SEX: Male
6. COLOR OR RACE: Unknown
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (Last birthday) yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, M
10. (a) TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE (Give kind of work done during most of working life, even if retired): None
(b) KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) No (If yes give war or date of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Maryland State Police — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Prematurity- Six months gestation
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
This premature infant was found under a culvert by children playing in the vicinity, no information available
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None apparent
20c. TIME OF INJURY: Month, Day, Year — Hour o'clock — a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above and on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): James T. Andrews, M.D.
Address (Street, Town, or County): Indian Head, Md.
22. DATE SIGNED: 9-2-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/3/1966
23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
23d. LOCATION (City or Town) (County) (State): La Plata, Md.

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.
25a. REC'D BY REGISTRAR — DATE: SEP 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12670

1. PLACE OF DEATH
a. COUNTY: Charles County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata Md
c. LENGTH OF STAY IN 1b: Two Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last

4. DATE OF DEATH: Month — Day — Year 19

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph A.Brown

14. MOTHER'S MAIDEN NAME: Mary O.Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from — , 19 — to — , 19 — , that (I) (we) last saw the deceased alive on — , 19 — , and that death occurred at — M. from the causes and on the date stated above.

22a. SIGNATURE: James Andrews M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): James E. Andrews MD

22d. ADDRESS: Indian Head Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept.28,1966

23c. NAME OF CEMETERY OR CREMATORY: St. Charles

23d. LOCATION (City, town or county) (State): Glymont,Charles Co.,Md.

24. FUNERAL DIRECTOR — ADDRESS: Johnson Funeral Home,Pomonkey,Md.

25a. REC'D BY REGISTRAR DATE

25b. REGISTRAR'S SIGNATURE

VR A15 (4)
20M 1/65

Joseph A.Brown

Mary O.Gray

Indian Head
Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12677

CERTIFICATE OF DEATH

12671

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Physicans Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CoBB ISLAND
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Douglas — Middle L. — Last Wise

4. DATE OF DEATH: Month SEPTEMBER — Day 28 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27, 1966

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months / Days 1 — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): La Plata , Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DONALD JAMES WISE

14. MOTHER'S MAIDEN NAME: MYRNA NANETTE STEPHENS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Donald James Wise — Address: Cobb Island Md. 20625

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiorespiratory Failure
DUE TO (b): Prematurity
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1735
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/27, 1966, to 9/28/, 1966, that (I) (we) last saw the deceased alive on 9/28/ 1966, and that death occurred at 8:44 A.M., from causes and on the date stated above.

22a. SIGNATURE: George Norman Schultz M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 9/28/66

22c. PHYSICIAN'S NAME (Type): George N. Schultz ,M.D.

22d. ADDRESS: La Plata , Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/29/1966

23c. NAME OF CEMETERY OR CREMATORY: Holy Ghost Cemetery

23d. LOCATION (City or Town) (County) (State): Issue , Maryland

24. FUNERAL DIRECTOR — ADDRESS: Arehart Funeral Home, Inc.-La Plata, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 30 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

124653

1

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12675 12672

1. PLACE OF DEATH
a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, Resident before admission)
a. STATE Md. b. COUNTY Chas.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pharshile R 2 Conus
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First SYDNEY Middle EMANUEL Last WOODLAND
4. DATE OF DEATH Month 9 Day 12 Year 66
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-3-07
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY Food Chicken
11. BIRTHPLACE (State or foreign country) Charles
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME James H Woodland
14. MOTHER'S MAIDEN NAME Virginia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address Veronica Mae Woodland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular Renal Disease
DUE TO (b) Heart Dis 7
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH 7-66

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.
EXAMINER'S NAME (Type) [illegible]
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county)

22. DATE SIGNED 9-14-66

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9-18-66
23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Ceme
23d. LOCATION (City or Town) Pomfret (County) Charles (State) Md.
24. FUNERAL DIRECTOR W. K. Edelon ADDRESS Johnson Funeral Home, Pomonkey, Md.
25a. RECD. BY REGISTRAR DATE SEP 20 1966
25b. REGISTRAR'S SIGNATURE [signature] Charles Judge